

**SJS EXTENDED DAY PROGRAM
EMERGENCY FACT SHEET**

FAMILY NAME: _____			
<i>LAST NAME ONLY: If parent name is different from child's please use CHILD'S last name</i>			
ADDRESS: _____		TEL: ()	CELL: ()
#	Street	City	
CHILD'S NAME	D.O.B.	HOMEROOM	
PLACE WHERE PARENT/GUARDIAN CAN BE REACHED DURING THE DAY: <i>(between the hours of 8 am & 6 pm)</i>			
Mother's Name: _____		Father's Name: _____	
Cell Phone: _____		Cell Phone: _____	
Work Phone: _____		Work Phone: _____	
Email Address: _____			
PLEASE LIST THREE (3) PEOPLE WE CAN CONTACT IN CASE OF AN EMERGENCY:			
1)			
NAME	PHONE #	RELATIONSHIP	
2)			
NAME	PHONE #	RELATIONSHIP	
3)			
NAME	PHONE #	RELATIONSHIP	
PHYSICIAN'S NAME: _____			TEL #: ()
ADDRESS: _____			
DENTIST'S NAME: _____			TEL#: ()
ADDRESS: _____			
EMERGENCY MEDICAL INFORMATION: <i>(food, insect, medication allergies; medication taken on a regular basis; EpiPen?)</i>			
HEALTH INSURANCE: _____			
Please list individuals with permission to pick up your child. Your child will only be released to the individual(s) listed. PLEASE NOTE: A photo ID may be required to be shown as proof of identity if an individual is not known to the teacher(s).			
NAME	RELATIONSHIP	NAME	RELATIONSHIP
NAME	RELATIONSHIP	NAME	RELATIONSHIP
NAME	RELATIONSHIP	NAME	RELATIONSHIP
PARENT SIGNATURE		DATE	
2016-2017			